

EXHIBIT A

Product: **Direct Access**
Group Name: **YWCA OF BERGEN COUNTY**
Group Number: **085916-010**
6617-4

TABLE OF CONTENTS

	<u>Page</u>
Introduction	5
Certificate of Coverage.....	6
Definitions	7
Schedule of Covered Services and Supplies.....	27
Covered Basic Services and Supplies	29
Covered Supplemental Services and Supplies	37
General Information.....	39
How To Enroll	39
Your Identification (ID) Card	39
Types Of Coverage Available.....	39
Change In Type Coverage	39
Enrollment of Dependents.....	40
Special Enrollment Periods	41
Individual Losing Other Coverage	41
New Dependents.....	41
Special Enrollment Due to Marriage	42
Special Enrollment Due to Newborn/Adopted Children.....	42
Multiple Employment.....	42
Eligible Dependents	42
Student Dependent Coverage.....	44
When Coverage Ends	44
Benefits After Termination	45
If You Leave Your Group Due To Total Disability.....	45
Extension of Coverage Due to Termination of the Group Policy.....	45
Continued Coverage Under the Federal Family and Medical Leave Act.....	46
Continued Coverage for Surviving Dependents	46
Continuation of Coverage under COBRA.....	46
Continuation of Coverage under the USERRA.....	48
Continued Coverage for Over-Age Dependents	49
Conversion Coverage.....	53
Continuation of Care	53
Medical Necessity and Appropriateness	54
Cost Containment	55
Managed Care Provisions	55
Choosing a PCP	55
Your Horizon BCBSNJ Program	57
The Deductible	57
Family Aggregate Deductible	57
Out-of-Pocket Maximum	57
Payment Limits	58

Benefits From Other Plans	58
If This Program Replaces Another Plan.....	58
Pre-Existing Conditions.....	58
Creditable Coverage.....	59
Summary of Covered Services and Supplies	60
Covered Basic Services and Supplies	60
Alcoholism.....	60
Allergy Testing and Treatment	60
Ambulatory Surgery.....	60
Anesthesia	60
Audiology Services.....	60
Biologically-Based Mental Illness, Non-Biologically-Based Mental Illness and Substance Abuse	61
Birthing Centers	61
Dental Care and Treatment.....	62
Diagnostic X-rays and Lab-Tests	62
Domestic Violence	62
Emergency Room	62
Facility Charges	63
Fertility Services	63
Health Wellness.....	66
Home Health Care	69
Hospice Care	69
Inpatient Physician Services.....	71
Mastectomy Benefits.....	71
Maternity/Obstetrical Care	71
Maternity/Obstetrical Care for Child Dependents.....	72
Medical Emergency and Medical Screening Examinations	72
Nutritional Counseling	73
Orthotic Devices.....	73
Practitioner's Charges for Non-Surgical Care and Treatment.....	73
Practitioner's Charges for Surgery	73
Pre-Admission Testing Charges	73
Prosthetic Devices	73
Second Opinion Charges	74
Skilled Nursing Facility Charges.....	74
Specialist Services	74
Specialist-Language Pathology Services	74
Surgical Services	74
Therapeutic Manipulation.....	75
Therapy Services.....	75
Transplant Benefits.....	75
Urgent Care.....	77
Vision Care.....	77
Wilm's Tumor	77
Covered Supplemental Services and Supplies	77

Ambulance Services.....	77
Blood.....	78
Diabetes Benefits.....	78
Durable Medical Equipment	79
Inherited Metabolic Disease	79
Oxygen and its Administration	80
Physical Rehabilitation	80
Private Duty Nursing Care.....	80
Specialized Non-Standard Infant Formulas	80
Wigs Benefit	80
 Utilization Review and Management.....	82
 Utilization Review - Required Hospital Stay Review	82
 Notice of Hospital Admission Required	82
 Pre-Acknowledgment Review	83
 Continued Stay Review.....	83
 Penalties for Non-Compliance.....	84
 Medical Appropriateness Review Procedure	84
 Alternate Treatment Features/Individual Case Management.....	85
 Centers of Excellence Features	87
Schedule of Procedures Requiring Prior Authorization	88
Exclusions	90
 Coordination of Benefits and Services.....	97
 Purpose of this Provision	97
 Definitions	97
 Primary and Secondary Plan	98
 Rules for the Order of Benefit Determination	99
 Procedures to be Followed by the Secondary Plan to Calculate Benefits.....	100
 Benefits Payable for Automobile Related Injuries	103
 The Effect of Medicare on Benefits.....	105
 Important Notice	105
 Medicare by Reason of Disability.....	106
 Medicare Eligibility by Reason of End Stage Renal Disease.....	107
 Dual Medicare Eligibility	107
 How To File A Claim If You Are Eligible For Medicare	107
 Claims Procedures	109
 Appeals Process	113
 Covered Persons' Rights	117
 Statement of ERISA Rights.....	118
 Service Centers	120
 Civil Union Rider.....	121

INTRODUCTION

This Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) Direct Access Program gives you and your covered Dependents broad protection to help meet the cost of Illnesses and Accidental Injuries. This Program offers the highest level of benefits when services are obtained from a Hospital or other Provider designated as a Direct Access In-Network Provider either in New Jersey or in another Blue Cross and Blue Shield service area.

In this Booklet, you'll find the important features of your group's Direct Access benefits provided by Horizon BCBSNJ. You should keep this Booklet in a safe place and read it carefully so that you become familiar with the benefits that are available to you and your family. This Booklet replaces any booklets and/or certificates you may previously have received.

Coverage under this Program is provided according to the Group Policy for each Covered Person. Your Booklet's Schedule of Covered Services and Supplies shows the Policyholder and the Group Policy Number(s).

Benefits and Amounts:

The available benefits and the amounts of insurance are described in the Booklet.

This Booklet is an important document and should be kept in a safe place. When you become covered under the Program, you will receive a Certificate of Coverage. You should attach the Certificate of Coverage to this Booklet. Together, they form your Group Insurance Certificate.

The Booklet is made part of the Group Policy, which is delivered in and governed by the laws of the State of New Jersey. Future changes in coverage will be described in either a Booklet Notice of Change or in a new Booklet. All benefits are subject in every way to the entire Group Policy, which includes this Booklet.

**Horizon Healthcare Services, Inc. (d/b/a Horizon Blue Cross Blue Shield of New Jersey
(Horizon BCBSNJ))**

**3 Penn Plaza East
Newark, New Jersey 07105-2200**

HORIZON HEALTHCARE SERVICES, INC

CERTIFICATE OF COVERAGE

Horizon Healthcare Services, Inc. (Horizon BCBSNJ) certifies that insurance is provided according to the applicable Group Policy for each insured Employee. Your Booklet's Schedule of Covered Services and Supplies shows the Group Policyholder and the Group Policy Number.

Insured Employee: You are insured under the Group Policy. This Certificate of Coverage together with your Booklet forms your Group Insurance Certificate.

Your Booklet and this Certificate of Coverage replace any older booklets and certificates issued to you for the coverage described in your Booklet. The Booklet and Certificate of Coverage are made part of the Group Policy, which is delivered in and governed by the laws of the State of New Jersey. Future changes in coverage will be described in either a Booklet Notice of Change or new Booklet. All benefits are subject in every way to the entire Group Policy, which includes this Group Insurance Certificate.

Horizon Healthcare Services, Inc.
3 Penn Plaza East
Newark, New Jersey 07105-2200

DEFINITIONS

This section defines certain important terms used in this Booklet. The meaning of each defined word, whenever it appears in this Booklet, is governed by its definition below.

Act of War: Any act peculiar to military, naval or air operations in time of War.

Active: Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.

Admission: Days of Inpatient services provided to a Covered Person.

Affidavit of Domestic Partner/Statement of Domestic Partnership: A formal instrument executed by two persons documenting their status as Domestic Partners. Submission of an Affidavit of Domestic Partnership/ Statement of Domestic Partnership to the Group and Horizon BCBSNJ is required prior to Domestic Partner coverage becoming effective. In order to be a valid Affidavit of Domestic Partnership/ Statement of Domestic Partnership for purposes of your group's Policy, the definition of Domestic Partners contained therein must be identical to the definition contained in the definition of Domestic Partner.

Affiliated Company: A corporation or other business entity affiliated with the Policyholder through common ownership of stock or assets; or as otherwise defined by the Policyholder and Horizon BCBSNJ.

Alcoholism: The abuse of or addiction to alcohol.

Allowance: An amount determined by Horizon BCBSNJ as the least of the following amounts: (a) the actual charge made by the provider for the service or supply; or (b) in the case of In-Network Providers, the amount that the provider has agreed to accept for the service or supply; or (c) in the case of Out-of-Network Providers, the amount determined for the service or supply based on the Resource Based Relative Value System promulgated by the Centers for Medicare and Medicaid Services; or (d) in the case of Out-of-Network Providers, an amount determined for the service or supply based on: (i) profiles compiled by Horizon BCBSNJ based on the usual and prevailing payments made to providers for similar services or supplies in specific geographical areas; or (ii) similar profiles compiled by outside vendors. In a case where a Covered Person's Primary Care Physician (PCP) refers him/her to an Out-of-Network Provider's services will be the amount determined in accordance with (a), above.

The above methods for determining an Allowance do not apply with respect to the Program coverage of Orthotic and Prosthetic Devices. The Allowance for any such covered device shall be the greater of: (a) the reimbursement rate for the device in the federal Medicare reimbursement schedule; and (b) in the case of In-Network Providers, the amount that the Provider has agreed to accept for the device. If there is no such rate for the device, the amount determined for (a) shall be the Medicare reimbursement rate for the most similar device.

Alternate Payee:

SCHEDULE OF COVERED SERVICES AND SUPPLIES

POLICYHOLDER: YWCA OF BERGEN COUNTY

GROUP POLICY NO.: 085916

BENEFITS FOR COVERED SERVICES OR SUPPLIES UNDER THIS PROGRAM ARE SUBJECT TO ANY AND ALL DEDUCTIBLE(S), COPAYMENT(S), COINSURANCE(S) AND MAXIMUM(S) STATED IN THIS SCHEDULE AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

NOTE: OUR BENEFITS WILL BE REDUCED FOR NON-COMPLIANCE WITH THE UTILIZATION REVIEW AND MANAGEMENT PROVISIONS OF THIS PROGRAM.

REFER TO THE "EXCLUSIONS" AND "SUMMARY OF COVERED SERVICES AND SUPPLIES" SECTIONS OF THIS BOOKLET TO SEE WHAT SERVICES AND SUPPLIES ARE NOT COVERED.

Horizon BCBSNJ will provide the coverage described in this Schedule of Covered Services and Supplies. That coverage is subject to the terms, conditions, limitations and exclusions stated in this Booklet.

Services and supplies provided by an In-Network Provider, are covered at the In-Network level.

Services and supplies provided by an Out-of-Network Provider, are covered at the Out-of-Network level. However, this does not apply to services and supplies provided by an Out-of-Network Provider in a case where: (a) the Covered Person is an Inpatient in a Hospital; (b) the admitting physician was a Network Practitioner; and (c) the Covered Person and/or the Covered Person's Practitioner complied with this Program's rules with respect to Prior Authorization or notification. In this case, the Covered Services and Supplies provided by Out-of-Network Providers during the Inpatient stay will be covered at the In-Network level.

Please note that you may be responsible for paying charges which exceed our Allowance, when services are rendered by an Out-of-Network Provider.

The laws of the State of New Jersey, at N.J.S.A. 45:9-22.4 et seq. mandate that a physician, chiropractor or podiatrist inform his/her patients of any significant financial interest he/she may have in a Provider when making a referral to that Provider. If you want more information about this, contact your physician, chiropractor or podiatrist. If you believe that you are not receiving the information to which you are entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 or (800) 242-5846.

Different In-Network Providers have agreed to be paid in different ways. Your Provider may be paid: (a) each time he/she treats you (fee-for-service); or (b) a set fee each month for each Covered Person that the Provider treats, whether or not the Covered Person actually receives services (capitation). These payment methods may also include financial incentive agreements whereby some Providers are paid more (bonuses) or less (withholds), based on many factors.

Some of these factors are: member satisfaction; quality of care; control of costs; and use of services. If you want more information about how our Providers in our Network are paid, please call us at 1-800-355-2583 or write Horizon BCBSNJ, 3 Penn Plaza East, Newark, NJ 07105.

Coinsurance **100% of Covered Basic Charges.**
In-Network **100% of Covered Supplemental Charges.**

Coinsurance **70% of Covered Basic Charges.**
Out-of-Network **70% of Covered Supplemental Charges.**

Out-of-Pocket Maximum

In -Network **After \$5,000/Covered Person, \$10,000/family,
We provide 100% of Covered Allowance.**

Out-of-Network **After \$10,000/Covered Person, \$20,000/family,
We provide 100% of Covered Allowance.**

Note: The Out-of-Pocket Maximum cannot be met with:

- Non-Covered Charges

Deductible

**In-Network &
Out-of-Network** **\$2,500/Single
\$5,000/Family (Note: May be aggregate met
by covered family members.)**
**Applies to
Basic/Supplemental
Services.**

Deductible does not apply to Preventive Care.

Common Accident Deductible - If two or more Covered Persons in the same family are injured in the same accident, only one Deductible will be applied in a Benefit Period to the Covered Services and Supplies due to the accident.

Prior Carrier Deductible Carry-Over - Charges for Covered Services and Supplies which met any portion of a Deductible required for the final Benefit Period under the Policyholder's prior group health benefits contract will be applied to meet all or any portion of the initial Deductible under this Program.

BENEFIT PERIOD MAXIMUM

**In-Network and
Out-of-Network** **Unlimited. Applies to all Covered Services and Supplies.**

PER LIFETIME MAXIMUM

In-Network and

EXCLUSIONS

The following are not Covered Services and Supplies under this Program. Horizon BCBSNJ will not pay for any charges Incurred for, or in connection with:

Acupuncture.

Administration of oxygen, except as otherwise stated in this Booklet.

Ambulance, in the case of a non-Medical Emergency.

Anesthesia and consultation services when they are given in connection with Non-Covered Charges.

Any part of a charge that exceeds the Allowance.

Any therapy not included in the definition of Therapy Services.

Bariatric Surgery.

Biofeedback services.

Blood or blood plasma or other blood derivatives or components that are replaced by a Covered Person.

Broken appointments.

Charges Incurred during a Covered Person's temporary absence from a Provider's grounds before discharge.

Completion of claim forms.

Conditions classified as V-codes in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. These include relational problems such as: parent-child conflicts; problems related to abuse or neglect when intervention is focused on the perpetrator; and situations not attributable to a diagnosable disorder, including bereavement, academic, occupational, religious and spiritual problems.

Conditions related to behavior problems or learning disabilities, except as may be required by law with respect to the treatment of Biologically-based mental Illness.

Conditions which Horizon BCBSNJ determines to be due to developmental disorders. These include, but are not limited to: mental retardation; academic skills disorders; or motor skills disorders. But, this does not apply: (a) to the treatment of Biologically-based Mental Illness; or disorders (b) to the extent needed to provide newly born dependents with coverage for Injury or Illness, including the necessary care and treatment of medically diagnosed congenital defects and abnormalities.